MassHealth

# Companion Guide
## Health-Care Claim: Institutional
## For ASC X12N 837 (version 4010A1)

## Table of Contents

## 1.0    Introduction

### 1.1    What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 — Administrative Simplification (HIPAA-AS) requires that MassHealth and all other health insurance payers in the United States comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services (HHS).  HHS has adopted an Implementation Guide for each standard transaction.  Version 0004010X096A1 of the 837 Institutional transaction is the standard established by HHS for institutional claims submission.

### 1.2    Purpose of the Implementation Guide

The Implementation Guide for the 837 Institutional claim transaction specifies in detail the required formats for claims submitted electronically to an insurance company, health-care payer, or government agency.  The implementation guide contains requirements for use of specific segments and specific data elements within the segments, and was written for all health-care providers and other submitters.  It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to MassHealth.

### 1.3    How to Obtain Copies of the Implementation Guides

The 837I implementation guides for X12N 837I version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA.

### 1.4    Purpose of This Companion Guide

This 837I Companion Guide was created for MassHealth trading partners by MassHealth to supplement the 837I Implementation Guide.  It contains MassHealth-specific instructions for the following:

- data content, codes, business rules, and characteristics of the 837I transaction;
- technical requirements and transmission options; and
- information on testing procedures that each trading partner must complete before submitting 837I claims.

The information in this guide supersedes all previous communications from MassHealth about this electronic transaction.  The following policies are in addition to those outlined in the MassHealthprovider manuals for individual claim types.  These policies in no way supersede MassHealth regulations.  This companion guide should be used in conjunction with the information found in your MassHealth provider manual.

## 1.5   Intended Audience

The intended audience for this document is the technical staff responsible for submitting electronic 837I claims to MassHealth.  In addition, this information should be shared with the provider's billing office to ensure that all required billing information is available for claim submission.

## 2.0   Establishing Connectivity with MassHealth

MassHealth is currently assessing network options for trading partners to transmit electronic transactions to MassHealth.  An External Trading Partner Network (ETPN) will be established for the use of MassHealth trading partners.  Until such a network is established, MassHealth trading partners should coordinate the transmission of 837I claims with MassHealth Customer Service at 1-800-841-2900 or e-mail hipaasupport@mahealth.net. *The information provided in this companion guide will be revised as the ETPN is implemented.*

## 2.1   Setup

All MassHealth trading partners must sign a Trading Partner Agreement (TPA) and will be requested to complete a trading partner profile (TPP) form before submitting electronic 837 transactions.  Note that TPP information may be given over the telephone in lieu of completing a paper form.  If you have already completed these forms, you do not have to complete them again.  Please contact MassHealth Customer Service at 1-800-841-2900 (see Section 2.5:  Support Contact Information) if you have any questions about these forms.

MassHealth trading partners should submit HIPAA 837I claims to MassHealth via the transactions Web site or if necessary, on hard media (for example, CD-ROM). Trading partners must contact MassHealth Customer Service at 1-800-841-2900 with questions about these options.

After establishing a transmission method, each trading partner must successfully complete testing.  Information on this phase is provided in the next section of this companion guide (see Section 2.2:  Trading Partner Testing).  After successful completion of testing, 837I transactions may be submitted for production processing.

All hard media (testing and production claims) must prominently display the file name on the label, along with the identifying information described below. The external label on the hard media must appear as follows:

| | |
|---|---|
| Header: | *MassHealth Submission* |
| File Name: | *As determined by the submitter following the appropriate file-naming convention for test or production claims* |
| Transaction Type: | *Institutional* |
| MassHealth Submitter/ Pay-to-Provider number: | *The MassHealth number of the provider or billing intermediary submitting the hard media* |
| Submitter Name: | *The name of the provider or billing intermediary submitting the hard media* |
| Submission Date: | *MM/DD/YY* |
| Contact Name: | *The name of the person to contact if MassHealth has a problem with the hard media* |
| Contact Information: | *Telephone number and/or e-mail address* |

## 2.2    Trading Partner Testing

Before submitting live 837 claims to MassHealth, each trading partner must be tested.  All trading partners who plan to submit 837I transactions must contact MassHealth Customer Service at 1-800-841-2900 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

If you are a current paper submitter or first-time submitter:
- We require a file with a minimum of 10 and a maximum of 50 test claims.
- The member and provider data must be valid for a mutually agreed upon effective date.

The following conditions must be addressed in one or more test files:

**The test files should contain as many types of claims as necessary to cover each of your business scenarios.**

- original claims;
- void claims (if you plan to submit void claims);
- replacement claims (if you plan to submit void transactions and replacement claims); and
- coordination of benefits claims (COB, if you plan to submit COB claims).

Providers submitting test files containing COB claims (where the member has other insurance) should include a minimum of 10 and a maximum of 50 COB claims with the following criteria:

- claims with commercial insurance (denied/paid);
- claims with Medicare (denied/paid);
- claims with multiple insurance, if applicable; and
- claims with COB overrides, if applicable to the submitter (certain provider types only as described in provider bulletins).

All test files, regardless of the type of services provided, should be submitted using the following naming convention for all media types:

- **T**YYYYYYY.ZZZ, where:
  - **T** is the letter "T" indicating Test data.
  - YYYYYYY is the seven-digit MassHealth Submitter ID/Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file by the Trading Partner, starting with a value of "001."
  - This sequence number should be increased by one for each subsequent test file that is submitted. The sequence number will restart at 001 after it reaches 999.

Providers are advised to submit the 835 remittance advice and/or the paper explanation of benefits (EOB) from the other insurer to be used in the testing process for verification of data in the COB loops. Providers must indicate which claims on the 835 remittance advice and/or paper EOB correspond to the claims on the test file.

MassHealth will process these transactions in a test environment to validate that the file structure and content meet HIPAA standards and MassHealth-specific data requirements. Once this validation is complete, the trading partner may submit production 837I transactions to MassHealth for adjudication. **Test claims will not be adjudicated.**

## 2.3    Technical Requirements

The current maximum file size for any 837 file submitted to MassHealth is 16 megabytes. If you are uploading multiple 837 files using the transactions Web site, the maximum is sixteen megabytes per upload, not per file. You can also submit your claims in a compressed zip file that contains no more than 99 claim files. If you have questions, contact MassHealth Customer Service at 1-800-841-2900 (see Section 2.5: Support Contact Information).

MassHealth endorses the ASC recommendation that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5,000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

## 2.4    Acknowledgements

Confirmation numbers are generated for all 837 transaction files uploaded to the Web portal, indicating a successful file upload.  997 functional acknowledgements are generated for all 837 files submitted to MassHealth.  These acknowledgements will be available for download from the transactions Web site.

MassHealth uses the tilde (~) segment terminator on all outbound HIPAA-compliant transactions. HIPAA-compliant outbound transactions from MassHealth include the 835 electronic remittance advice transactions and the 997 acknowledgements.

## 2.5    Support Contact Information

> MassHealth Customer Service
> Phone:  1-800-841-2900
> Fax:  617-988-8971
> P.O. Box 9118
> Hingham, MA  02043
> E-mail:  hipaasupport@mahealth.net

**All hard media containing claims must be mailed to the above address.**

## 3.0        MassHealth-Specific Submission Requirements

> *The following information is for production claims.  For test claims refer to the Trading Partner Testing section.*

The following sections outline recommendations, instructions, and conditional data requirements for 837I claims submitted to MassHealth.  This information is designed to help trading partners construct the 837 transactions in a manner that will allow MassHealth to efficiently process claims.

## 3.1    Claims Attachments

An electronic standard for claims attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS).  Until then, MassHealth has developed an alternative method for handling electronic claims (for example, medical forms, consent forms, etc.) that require attachments under HIPAA. **Note:  "Attachments" does not refer to coordination of benefits (COB) attachments such as an explanation of benefits (EOB).  See Section 3.3:** Coordination of Benefits (COB) **for more information.**

When MassHealth receives a claim requiring an attachment, it is suspended and a claims attachment form (CAF) is mailed to the provider.  The CAF contains information relevant to the claim, including but not limited to patient name, MassHealth ID number, date of service, error number, and reason the attachment is being requested.  The provider must return the CAF with the required attachment within 45 days of the date on the CAF to the following address:

**MassHealth Customer Service**
**Attention:  Claims**
**P.O. Box 9118**
**Hingham, MA  02043**

The claim will be held in suspense for 45 days to await receipt of the attachment.  This time period will not count against the **initial** 90-day billing deadline.  Failure to submit attachments with the CAF within 45 days of the date on the CAF will cause the suspended claim to deny for Edit 360: "No response to our CAF."

*Until a standard for electronic attachments is finalized by CMS, providers and billing intermediaries submitting HIPAA claims to MassHealth must follow the CAF process to properly adjudicate claims requiring attachments.  This does not alter the current method of claim and attachment submission via paper, which will continue to be available to providers.*

MassHealth has reviewed its requirements for attachments, and will be allowing the following attachments to be kept on file rather than requiring them to be submitted with the claim or through the CAF process.

| If you submit this type of attachment… | and you are this provider type… | you may keep the attachment on file (Code to enter in PWK02) |
|---|---|---|
| Certification for Payable Abortion (CPA-2) form | Acute Inpatient Hospital Acute Outpatient Hospital | PWK02 = AA |

Please refer to the Detail Data section for instructions on completing the PWK segment.

*All attachments not listed above (with the exception of coordination of benefits attachments such as an explanation of benefits) must continue to be submitted, either with a paper claim or via the CAF process.*

Periodically, MassHealth may ask providers to verify the completion of attachments kept on file.  In cases where MassHealth reviews have revealed provider noncompliance with the recordkeeping requirements of 130 CMR 450.205(A) through (C), MassHealth may pursue any legal remedies available to it, including but not limited to recovery of overpayments and imposing sanctions in accordance with the provisions of 130 CMR 450.234 through 450.260.

## 3.2    Encounter Claims

MassHealth does not accept encounter claims.  For further details, see Section 3.6:  Detail Data.

## 3.3    Coordination of Benefits (COB)

The implementation of the 837 transaction enables providers to submit claims for members with other insurance electronically to MassHealth, after billing all other resources.  Claims for dually entitled (Medicare/MassHealth) members that have been approved by Medicare will continue to be forwarded electronically to MassHealth by Medicare fiscal intermediaries and carriers that have an agreement with MassHealth.  Claims where Medicare is the secondary payer or the member has Medicare supplemental insurance must be submitted to MassHealth by the provider.  MassHealth is in the process of pursuing an electronic claims process with other Medicare fiscal intermediaries and carriers that process claims for MassHealth members.  Until this is in place, providers must submit claims adjudicated by Medicare to MassHealth when there is no agreement between MassHealth and the Medicare fiscal intermediary or carrier.

When submitting an 837 transaction to MassHealth for members with other insurance, providers must supply the other payer's adjudication details that were provided on the 835 remittance transaction.  Providers are required to enter the other payer's adjudication details at the claim level.  Line-level adjudication details are required for outpatient, home health, and hospice claims.  The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer.  Altering the adjudication details given by the other payer is considered fraudulent.

In addition, since the National Plan Identification number rule has not been finalized, MassHealth requires providers to enter the MassHealth-assigned carrier code on the 837 transaction to identify the other insurance.  The MassHealth Recipient Eligibility Verification System (REVS) provides a five-digit insurance carrier code for all applicable insurance coverage for a member.

After billing all resources before billing MassHealth, enter the first three digits of the other payer's carrier code on the 837 transaction.  To ensure accurate processing, the three-digit carrier codes entered on the 837 transaction must match the first three digits of the carrier code given by REVS.  See Section 3.7:  Detail Data for COB Claims for more details.

### 3.3.1    COB Bundled Claims

MassHealth will process claims for services that are bundled by a commercial insurance or Medicare as a bundled claim.  If you need to correct a bundled claim, you must void all paid service lines associated with the bundled claim, make the necessary corrections to the claim, and resubmit the bundled claim as an original 837 transaction.

## 3.4    Void Transactions

> **Please Note:  Under HIPAA guidelines, adjustments to paid claims should be submitted as a void/replace transaction.**

Void transactions are used by submitters to correct and report any one of the following situations:

- duplicate claim erroneously paid;
- payment to the wrong provider;
- payment for the wrong member;
- payment for overstated or understated services; and
- payment for services for which payment has been received from third-party payers.

Void transactions must be submitted for one service line at a time to accommodate MassHealth processing rules.  For example, if a provider wishes to void out a claim that was originally submitted with three service lines, the provider would have to submit three void transactions. Each transaction would be for one of the service lines and must include the original MassHealth-generated transaction control number (TCN) for the service as the "Former TCN" with a claim frequency code equal to "8."

## 3.5    Production File-Naming Convention

837 files transmitted to MassHealth using the Web site may use any convenient file-naming convention.  The system will rename files upon receipt and issue a tracking number for reference. 837 files transmitted to MassHealth via hard media must adhere to the following naming convention:

- **H**YYYYYYY.ZZZ, where:
    - **H** is the letter "H", which indicates a HIPAA-compliant production file.
    - YYYYYYY is the seven-digit MassHealth Submitter/Pay-to-Provider number.
    - ZZZ is the sequence number assigned to the file starting with a value of "001."
    - The sequence number should be increased by one for each subsequent file that is submitted. The sequence number will restart at 001 after it reaches 999.

## 3.6 Detail Data

Although submitters can view the entire set of required data elements in the 837I Implementation Guide, MassHealth recommends that submitters pay special attention to the following segments as these segments have already generated questions.

| Loop | Segment | | Element Name | Companion Information |
|------|---------|---|--------------|-----------------------|
| ---- | ISA | 05 | Interchange Sender ID Qualifier | Enter "ZZ" |
| ---- | ISA | 06 | Interchange Sender ID | Your seven-digit MassHealth provider number/ pay-to provider number. |
| ---- | ISA | 07 | Interchange Receiver ID Qualifier | Enter "ZZ" |
| ---- | ISA | 08 | Interchange Receiver ID | Enter "DMA7384" |
| ---- | ISA | 15 | Interchange Usage Indicator | This element is used to indicate whether the transmission is in a test or production mode. A "P" indicates production data, and a "T" indicates test data. |
| ---- | GS | 02 | Application Sender's Code | your seven-digit MassHealth submitter ID/pay-to provider number |
| ---- | GS | 03 | Application Receiver's Code | Enter "DMA7384" |
| ---- | BHT | 06 | Transaction Type Code | In the Beginning of Hierarchical Transaction (BHT) loop, BHT06 should always be equal to "CH," and all submitted 837 transactions should be claims for payment. A set of encounters, indicated by BHT06 equal to "RP," will pass compliance checks but no transactions within the set will be released to the adjudication system. |
| 1000A | NM1 | 09 | Submitter Name | your seven-digit MassHealth submitter ID |
| 1000B | NM1 | 09 | Receiver Name | Enter "DMA7384" |
| 2000B | SBR | 09 | Subscriber Information Claim Filing Indicator Code | Enter "MC" |
| 2010AA | REF | 01 | Billing Provider Name/Billing Provider Secondary Identification Number | If 2010AA REF01 equals "1D" and 2010AA REF02 is numeric and greater than zero, move 2010AA REF02 to A-SERV-PROV. |
| 2010AA | REF | 02 | Billing Provider Secondary Identification Number/Reference Identification | REF01 is "1D" and REF02 is the seven-digit MassHealth provider number of the entity doing the billing. For example, a billing agency number, a provider group number, or an individual provider. |

| Loop | Segment | | Element Name | Companion Information |
|---|---|---|---|---|
| 2010AB | REF | 01 | Pay-To Provider's Name/Pay-To Provider Secondary Identification Number | If 2010AB REF01 equals "1D" and 2010AB REF02 is numeric and greater than zero, move 2010AB REF02 to A-SERV-PROV. |
| 2010AB | REF | 02 | Pay to Provider Secondary Identification Number/Reference Identification (Pay-to Provider Identifier) | REF01 is "1D" and REF02 is the seven-digit MassHealth provider number identifying the group or individual provider receiving the payment.  If this segment is not submitted, the billing provider number from the 2010AA segment is used as the pay-to provider number. |
| 2010BA | NM1 | 09 | Subscriber Name/Identification Code | 10-character MassHealth member's recipient identification number (RID) when NM108 is "MI" and NM102 is "1." |
| 2300 | CLM | 05-1 | Claim Information Facility Code Value (Facility Type Code) | The 837I format uses the first two characters of Bill Type to establish place of service for the entire claim. |
| 2300 | REF | 01/02 | Prior Authorization or Referral Number | If prior authorization exists, enter "G1" in REF01 and enter the MassHealth assigned six-character prior-authorization number in REF02 (also see 2400 REF01/REF02 Prior Authorization or Referral Number.) |
| 2300 | REF | 01/02 | Prior Authorization or Referral Number | Enter "9F" in REF01 and the PCC's seven-digit referral number in REF02 if the member you are billing for is enrolled in a PCC Plan and all services being billed for require PCC authorization (also see 2400 REF01/REF02 Prior Authorization or Referral Number.) |
| 2300 | REF | 01/02 | Original Reference Number/Reference Identification | If submitting a void or replace transaction, enter "F8" in REF01 and the 10-character transaction control number (TCN) from the original claim. |
| 2300 | REF | 01/02 | Preadmission Screening Reference Number | If preadmission screening is required for this claim, enter "G4" in REF01 and the assigned six-digit preadmission screening number in REF02. |
| 2300 | AMT | 01/02 | Patient Estimated Amount Due | If there is a patient paid amount associated with the services provided, enter "F3" in REF01 and the amount of the patient paid amount in REF02. |
| 2300 | PWK | 01 | Report Type Code | This code indicates the title of a document, report, or supporting information to be submitted separately.  Enter date and time of each visit on claims. |

| Loop | Segment | | Element Name | Companion Information |
|------|---------|---|--------------|----------------------|
| 2300 | PWK | 02 | Report Transmission Code | Enter "AA" (available on request at provider site). Claims submitted with a transmission code of "AA" will notify MassHealth that the attachment is one of the approved attachments allowed to be kept on file at the provider's office. Enter date and time of each visit on claims. |
| 2300 | HI | 01-1, 02-1, 03-1, 04-1, 05-1, 06-1, 07-1, 08-1, 09-1, 10-1, 11-1, 12-1 | Claim Information/Occurrence Span Information<br><br>Code List Qualifier Code | If you are reporting medical or nonmedical leave days, enter "BI" here.<br><br>This field allows for up to three separate occurrences of medical or nonmedical leave days. |
| 2300 | HI | 01-2, 02-2, 03-2, 04-2, 05-2, 06-2, 07-2, 08-2, 09-2, 10-2, 11-2, 12-2 | Claim Information/Occurrence Span Information<br><br>Industry Code (Occurrence Span Code) | Enter "X0" here to indicate medical leave days. Enter "X1" to indicate nonmedical leave days. |
| 2300 | HI | 01-3, 02-3, 03-3, 04-3, 05-3, 06-3, 07-3, 08-3, 09-3, 10-3, 11-3, 12-3 | Claim Information/Occurrence Span Information<br><br>Date Time Period Format Qualifier (Occurrence Span Code Associated Date) | If you are indicating medical or nonmedical leave days, enter the start date. |
| 2300 | HI | 01-4, 02-4, 03-4, 04-4, 05-4, 06-4, 07-4, 08-4, 09-4, 10-4, 11-4, 12-4 | Claim Information/Occurrence Span Information<br><br>Date Time Period (Occurrence Span Code Associated Date) | If you are indicating medical or non-medical leave days, enter the end date. |
| 2300 | HI | 01-2, 02-2, 03-2, 04-2, 05-2, 06-2, 07-2, 08-2, 09-2, 10-2, 11-2, 12-2 | Claim Information/Value Information | **If you are a rest home or nursing facility provider billing for a member occupying a rest home bed**, enter "BE" in the HIXX-1 field, "86" in the corresponding HIXX-2 field, and as indicated in the Implement-ation Guide, enter your daily MassHealth rate in the HIXX-5 field. |

| Loop | Segment | | Element Name | Companion Information |
|------|---------|---|--------------|----------------------|
| 2300 | DTE01 | | Admission Hour | **This is required for Acute Inpatient and Outpatient Hospitals**. Enter the hour the member was admitted for care. |
| 2310A | REF | 01/02 | Attending Physician Name/Attending Physician Secondary Identification<br><br>Reference Identification (Attending Physician Secondary Identifier) | **Hospice and home health providers do not need to use this field.** All other providers should enter the seven-digit MassHealth provider number of the attending physician in REF02 and "1D" in REF01, when known. If unknown or the attending physician is not a MassHealth provider, enter "9999990" in REF02 and "1D" in REF01. |
| 2310B | REF | 01/02 | Operating Physician Name/Operating Physician Secondary Identification<br><br>Reference Identification (Operating Physician Secondary Identifier) | If a surgical or obstetrical procedure was performed, enter the seven-digit MassHealth provider number of the practitioner who performed the principal procedure in REF02 and "1D" in REF01, when known. If unknown or the operating physician is not a MassHealth provider, enter "9999990" in REF02 and "1D" in REF01. |
| 2310C | REF | 01/02 | Other Provider Secondary Identification/Other Provider Name<br><br>Reference Identification (Other Provider Secondary Identifier) | Hospice and home health providers should enter a "1D" in REF01 and their seven-digit MassHealth provider number if this number is different from what was entered in either the 2010AA or 2010AB number. |
| 2400 | SV2 | 01 | Product/Service ID (Revenue Code) | If you are billing for home health services (previously billed on an Invoice 09), enter the appropriate revenue code in the 560, 570, and/or 580 ranges. If you are billing for hospice services (previously billed on an Invoice 09), enter the appropriate revenue code in the 650 range. |

| Loop | Segment | | Element Name | Companion Information |
|------|---------|---|--------------|----------------------|
| 2420A | REF | 01/02 | Attending Physician Name/Attending Physician Secondary Identification<br><br>Reference Identification (Attending Physician Secondary Identifier) | **Hospice and home health providers do not need to use these fields. All other providers should use these fields only if the attending provider information for this line is different from that in the 2310A (claim) loop.**<br><br>If you are not a hospice or home health provider and the attending provider information for this line is different from that in the 2310A (claim) loop, enter the seven-digit MassHealth provider number of the attending physician in REF02 and "1D" in REF01, when known. If unknown or the attending physician is not a MassHealth provider, enter "9999990" in REF02 and "1D" in REF01. |
| 2420B | REF | 01/02 | Operating Physician Name/Operating Physician Secondary Identification<br><br>Reference Identification Qualifier | **Use these fields only if a surgical or obstetrical procedure was performed and the operating provider information for this line is different from that in the 2310B (claim) loop.**<br><br>If a surgical or obstetrical procedure was performed and the operating provider information is different from that in the 2310B (claim) loop, enter the seven-digit MassHealth provider number of the practitioner who performed the principal procedure in REF02 and "1D" in REF01, when known. If unknown or the operating physician is not a MassHealth provider, enter "9999990" in REF02 and "1D" in REF01. |
| 2420C | REF | 01/02 | Other Provider Secondary Identification/Other Provider Name<br><br>Reference Identification (Other Provider Secondary Identifier) | Hospice and home health providers should enter a "1D" in REF01 and their seven-digit MassHealth provider number if this number is different from what was entered in either the 2010AA, 2010AB, or 2420C numbers. |

## 3.7    Detail Data for COB Claims

| Loop | Segment | | Element Name | Companion Information |
|------|---------|---|--------------|------------------------|
| 2330B | NM1 | 08 | Identification code qualifier | Enter "PI" for payer identification. |
| 2330B | NM1 | 09 | Other payer primary identifier | MassHealth assigned three-digit carrier code when NM108 is "PI" (see Appendix C: **Third-Party-Liability Codes** in your provider manual or refer to the Provider Library on the mass.gov Web site for information.) |
| 2430 | SVD | | Service Line Adjudication Information | Required if other payer has adjudicated the service line. |
| 2430 | CAS | | Service Line Adjustment | Required if other payer has not paid in full. All adjustment reason codes given by the other payer must be present. |

## 3.8    Additional Information

MassHealth does not process certain loops that do not apply to the MassHealth business model. For example, MassHealth does not process *2000C Patient Hierarchical Level* since there is no dependent coverage (all members are subscribers). In certain circumstances, these loops may be required in a compliant 837 transaction. However, the data content of these loops will not affect the MassHealth claims adjudication process.

The loops listed in the table below are not processed.

| Hierarchical Level | Loops Not Processed Within HL | Element Name |
|--------------------|-------------------------------|--------------|
| Header | 1000B | Receiver Name |
| 2000B Subscriber | 2010BB<br>2010BC<br>2010BD<br>2305<br>2310E<br>2330D<br>2330E<br>2330F<br>2330H | Credit/Debit Card Account Holder Name<br>Payer Name<br>Responsible Party Name<br>Home Health Care Plan Information<br>Service Line Facility Name<br>Other Payer Attending Provider<br>Other Payer Operating Provider<br>Other Payer Other Provider<br>Other Payer Service Facility Provider |
| 2000C Patient | 2010CA | Patient Name |

## 3.9    Service Codes

Please consult Subchapters 5 and 6 of your MassHealth provider manual for information on acceptable revenue and service codes.  This information is also available on the Web.

> **Home health agency, nursing facility, ICF-MR state school, and rest home providers who previously submitted claims using the MassHealth proprietary electronic formats for the no. 9 and no. 10 claim forms should consult the National Uniform Billing Committee (NUBC) code data for acceptable revenue codes.**
>
> **Hospice providers must use only those revenue codes found on the list of acceptable codes issued by MassHealth for all claims with dates of service on and after January 1, 2004.  The list of acceptable revenue codes was mailed to all hospice providers in December 2003, via _Transmittal Letter HOS-12_.**

## 4.0    Sample MassHealth Transactions

## Example of MassHealth 837I Transaction

```
ISA*00*      *00*      *ZZ*9999999      *ZZ*DMA7384      *030228*0934*U*00401*000000003*1*T*:
GS*HC*9999999*DMA7384*20030228*0934*3*X*004010X096A1
ST*837*30001
BHT*0019*00*484*20030228*0934*CH
REF*87*004010X096A1
NM1*41*2*MEDICAL CLAIMS*****46*9999999
PER*IC*JANE DOE*TE*8605551124*FX*8605551146
NM1*40*2*MA MEDICAID*****46*DMA7384
HL*1**20*1
PRV*PT*ZZ*103T00000X
NM1*85*2*BILLING AGENT*****24*123456789
N3*345 ZERO DRIVE
N4*ANDOVER*MA*01810
REF*1D*9812345
NM1*87*2*HOSPITAL*****24*987654321
N3*111 OVERHILL DRIVE
N4*ANDOVER*MA*01810
REF*1D*1111111
HL*2*1*22*0
SBR*P*18** Mass Health*****MC
NM1*IL*1*LAST*FIRST****MI*0101010101
N3*230 1ST AVE
N4*FALL RIVER*MA*02721
DMG*D8*19511204*F
NM1*PR*2*MEDICAID*****PI*DMA7384
CLM*12225850*10157.05***11:A:1*N*A*Y*Y********N
DTP*096*TM*1130
DTP*434*D8*20030116
DTP*435*DT*200204091242
CL1*2*1*01
AMT*F3*100.00
PWK*AS*EL***AC*123456
REF*G1*MAA36169000029
REF*F8*MAA36169000029
REF*EA*MAA36169000029
REF*G4*MAA36169000029
NTE*ADD* TEST TEST
HI*BK:29382
HI*BF:12345*BJ:2989*BN:E9320
HI*BR:8703:D8:20020327
HI*BQ:8871:D8:20020328*BQ:8741:D8:20020401*BQ:8703:D8:20020401
```

**Example of MassHealth 837I Transaction (cont)**

```
HI*BH:11:D8:20020330*BH:18:D8:19880430*BH:19:D8:19010101
HI*BE:37:::4.00*BE:39:::4.00
HI*BG:C5*BG:C6*BG:C5*BG:C5*BG:C5
QTY*CA*4*DA
HI*BI:11:RD8:20020330-20020402~
NM1*71*2*DOCTOR, ONE*****24*585858585
PRV*AT*ZZ*103T00000X
REF*1D*1212121
NM1*72*2*DOCTOR, TWO*****24*343434343
PRV*OP*ZZ*103T00001X
REF*1D*2121212
LX*1
SV2*0150*HC:270:21*2753.00*UN*1~
DTP*435*DT*200204091242
DTP*472*D8*20030201
```

## COB Claim

```
ISA*00*      *00*      *ZZ*0605638    *ZZ*DMA7384      *030306*1000*U*00401*000000049*0*P*:~
GS*HC*00181*112111001*20021106*1254*1*X*004010X096A1~
ST*837*0001~
BHT*0019*00*021119001*20021106*12542650*CH~
REF*87*004010X096A1~
NM1*41*2*XYZ SVC 81*****46*00189~
PER*IC*NOT LISTED*TE*8775679999~
NM1*40*2*MEDICAID*****46*112111001~
HL*1**20*1~
PRV*BI*ZZ*273R000999~
NM1*85*2*HEALTH XYZ HOSPITALS*****24*042103999~
N3*xx HOSPITAL ROAD~
N4*CITY*MA*014599004~
REF*1D*2299999~
HL*2*1*22*0~
SBR*S*18*112111001******ZZ~
NM1*IL*1*xxx*yyy*S***MI*01346623999~
N3*54 xyz RD*W~
N4*CITY*MA*019992008~
DMG*D8*19990508*F~
NM1*PR*2*MEDICAID*****PI*112111001~
N3*600 WASHINGTON ST.~
N4*BOSTON*MA*02111~
CLM*5006935999*5370.1***11:A:1*Y**Y*Y*********Y~
DTP*096*TM*1100~
DTP*434*RD8*20021011-20021016~
DTP*435*DT*200210110100~
CL1*1*1*01~
REF*EA*3611889~
HI*BK:29630*BJ:29630~
HI*DR:430~
HI*BF:30019*BF:3019*BF:2449*BF:27800*BF:7245*BF:V148*BF:V145~
HI*BE:08:::2030~
HI*BG:C5*BG:65~
QTY*CA*5*DA~
QTY*LA*5*DA~
NM1*71*1*XYZ*J****24*123456999~
PRV*AT*ZZ*203B000999~
REF*1G*9995339~
SBR*P*18**XXX*****CI~
CAS*CO*A2*3533.63~
AMT*C4*1836.47~
AMT*B6*5370.1~
AMT*N1*1836.47~
AMT*AA*1836.47~
DMG*D8*19700508*F~
OI***Y***Y~
NM1*IL*1*XXX*YYY*S***MI*01346623999~
N3*54 XYZ RD*W~
N4*TOWN*MA*019992008~
NM1*PR*2*XYZ 81*****PI*001991~
N3*2 XYZ DRIVE~
N4*TOWN*ME*041999911~
DTP*573*D8*20021106~
REF*F8*1229630212~
NM1*71*1~
REF*1G*9939533~
NM1*72*1~
REF*1G*9993533~
LX*1~
```

**COB Claim (cont)**

```
SV2*0124**4400*UN*5*880~
SVD*00181*0**0124*5~
DTP*573*D8*20021106~
LX*2~
SV2*0250**2.76*UN*2~
SVD*00181*0**0250*2~
DTP*573*D8*20021106~
LX*3~
SV2*0259**410.34*UN*95~
SVD*00181*0**0259*95~
DTP*573*D8*20021106~
LX*4~
SV2*0300**557*UN*13~
SVD*00181*0**0300*13~
DTP*573*D8*20021106~
SE*74*0001~
GE*1*1~
IEA*1*000000049~
```

## 5.0    Version Table

| Version | Date | Section/Pages | Description |
|---------|------|---------------|-------------|
| | 2/13/03 | Entire Document | Initial document created |
| 1.0 | 2/24/03 | Entire Document | Draft revision with updated MassHealth template |
| 1.1 | 3/3/03 | Entire Document | Draft revision after BA review |
| 1.2 | 4/8/03 | Entire Document | Draft revision after 837P edits were applied |
| 1.3 | 4/29/03 | Entire Document | Final revisions |
| 1.4 | | Entire Document | Draft revision after 837P edits applied |
| 1.5 | | | Draft version for posting on Web |
| 1.6 | 6/30/03 | | Production version issued |
| 1.7 | 09/11/03 | Entire Document | Production version issued |
| 1.8 | 11/24/03 | Links/text updated throughout document | Production version issued |
| 1.9 | 01/16/04 | Revisions to pages 12, 15, 21 | Additional Hospice information added to Service Codes section and Provider Types Map |
| 2.0 | 05/18/04 | Revisions to section 2.4 | Production version issued |
| 2.1 | 07/02/04 | Revision to page 11 | Production version issued |
| 2.2 | 12/09/04 | Update to Section 2.4 to reflect new Secure File Data information | Production version issued |
| 2.3 | 05/18/05 | Updates to Sections 2.3, 2.5, 3.0, 3.7, 3.9, Appendix B and Appendix C to reflect TPA and 60-day noticing. | Draft version issued. Production issue to follow |
| 2.4 | 10/05/05 | Update to Sections 2.3 regarding zip file submissions, 2.5 regarding support contact information, 3.1 zip code update, 3.5 update to file naming conventions, 3.6 update to Detail Data tables, and 3.10 regarding support contact information | Production version issued |
| 2.5 | 04/12/06 | Updates made to contact information and e-mail addresses throughout document.  Update to Sections 2.1 and 3.5 to clarify language, and references to disk/CDs have been changed to "hard media."  Updated Section 3.6 – Detail Data table, to reflect new OPD information.  Updated notation in section 2.4 indicating a change in file naming conventions to require only submitter name and contact name.  Updates made to Web links in Appendices B and C (Centers for Medicare and Medicaid Services (CMS). | Production version issued |

## Appendix A:    Frequently Asked Questions

**Q:** How can I receive 997 functional acknowledgements for rejects at the claim level rather than the transaction-set level?

**A:** The 997 acknowledges rejection of all claims within the ST/SE boundary.  The only way to receive a 997 rejection for each invalid claim is to submit your 837s with only one claim per transaction set.

**Q:** When applicable, should I use the place-of-service codes contained in the HIPAA Implementation Guide when submitting MassHealth paper claim forms too?

**A:** No, when submitting paper MassHealth claim forms requiring a place-of-service code, use the appropriate place-of-service code found in Subchapter 5 of your MassHealth provider manual.

**Q:** MassHealth has allowed outpatient departments that perform dental procedures to use the CDT codes and the CPT codes for oral surgery services.  The 837D Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process for an outpatient department to submit claims for oral surgery services using a CPT code?

**A:** Outpatient departments should submit oral surgery claims with CPT codes using the 837P claim format, and all other dental services using the 837D format.

**Q.** Hospitals billing on the paper UB92 claim form are required to enter revenue code 001 indicating "Total Charge" when submitting claims to MassHealth.  Should this revenue code be entered on an 837I transaction?

**A:** No, revenue code 001 is not required on the 837I transaction, but continues to be required on the paper UB92 claim form.

**Q.** If I identify other insurance that is not on file with MassHealth, how do I submit the claim?

**A:** Follow the standard process for any coordination of benefits (COB) claim.  To obtain the MassHealth-assigned carrier code, crossreference the insurance name with the appropriate carrier code in Appendix C of your provider manual, and enter the first three digits of the code on your 837 transaction.  Concurrently, you should request that the MassHealth file be updated by sending all pertinent information to the appropriate address below.

|  |  |  |
|---|---|---|
| MassHealth | or | MassHealth |
| Third-Party Liability Unit |  | Medicare Unit |
| P.O. Box 9251 |  | Schrafft Center |
| Chelsea, MA  02209 |  | 529 Main Street, 3$^{rd}$ Floor |
| Fax:  617-357-7604 |  | Charlestown, MA 02129-1120 |
|  |  | Fax:  617-886-8133 |

**Do not send claim forms to these addresses.**

## Appendix B:    Provider Types to Invoice Types Map

| If you currently submit MassHealth invoice type | …and you are this provider type | …and you are billing this allowable service[1] | …then use this HIPAA transaction |
|---|---|---|---|
| 01 | Acute inpatient hospital | Acute inpatient services | 837I |
| 01 | Chronic inpatient hospital | Chronic inpatient services | 837I |
| 01 | Psychiatric inpatient hospital | Psychiatric inpatient services | 837I |
| 01 | Non-RFA semi-acute inpatient hospital | Non-RFA semi-acute inpatient services | 837I |
| 01 | Intensive residential treatment program. | Intensive residential treatment program services | 837I |
| 03 | Non-RFA semi-acute outpatient hospital | Non-RFA semi-acute outpatient services | 837I |
| 03 | Acute outpatient hospital | Acute outpatient services | 837I |
| 03 | Hospital licensed health center | Hospital licensed health center services | 837I |
| 03 | Chronic outpatient hospital | Chronic outpatient services | 837I |
| 03 | Psychiatric outpatient hospital | Psychiatric outpatient services | 837I |
| 09 | Community health center (CHC)[2] | Home health services | 837I |
| 09 | Home health agency[2] | Home health services | 837I |
| 09 | Hospice[3] | Hospice services | 837I |
| 10 | Nursing facility[2] | Nursing facility services | 837I |
| 10 | ICF-MR state school[2] | ICF-MR services | 837I |
| 10 | Rest home[2] | Rest home services | 837I |

[1] Please consult Subchapters 5 and 6 of your MassHealth provider manual for information on acceptable revenue and service codes.

[2] Providers who previously submitted claims using the MassHealth proprietary electronic formats for the no. 9 and no. 10 claim forms should consult the National Uniform Billing Committee (NUBC) code data for acceptable revenue codes.

[3] Hospice providers must use only those revenue codes found of the list of acceptable codes issued by MassHealth for all claims with dates of service on and after January 1, 2004.  *The list of acceptable revenue codes was mailed to all hospice providers via Transmittal Letter HOS-12*.
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## Appendix C:     Links to Online HIPAA Resources

The following is a list of online resources that may be helpful.

### Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions.  www.x12.org

### American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS.  www.ahacentraloffice.org

### American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes.  www.ama-assn.org/

### Association for Electronic Health-care Transactions (AFEHCT)

- AFEHCT is a health-care association dedicated to promoting the interchange of electronic health-care information.  www.afehct.org

### Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Healthcare Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/default.asp?fromhcfadotgov=true.
- This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS).  www.cms.hhs.gov/MedHCPCSGenInfo/

### Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard-setting organizations and transaction change request system.  www.hipaa-dsmo.org

### Health Level Seven (HL7)

- HL7 is one of several ANSI-accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards.  www.hl7.org

### MassHealth

- The MassHealth Web site assists providers with HIPAA billing and policy questions, as well as provider enrollment support.  www.mass.gov/masshealth

### National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

## National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association and develops standards for institutional claims.  www.nubc.org

## National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association.  It develops and maintains a standardized data set for use by the noninstitutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

## Office for Civil Rights (OCR)

- OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA.  www.hhs.gov/ocr/hipaa

## United States Department of Health and Human Services (DHHS)

- The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA.  www.aspe.hhs.gov/admnsimp

## Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

## Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA.  www.wedi.org